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Circular Letter 1999-3

To: **All Health Care Insurers, Health Care Services Organizations, Hospital Service Corporations, Prepaid Dental Plan Organizations, Medical Service Corporations, Dental Service Corporations, Optometric Service Corporations, Utilization Review Agents, Insurance Trade Associations, External Independent Reviewers And Interested Parties**

From: **Charles R. Cohen
Director of Insurance**

Date: **June 11, 1999**

Re: **Compliance with Arizona's Health Care Appeals Laws**

All health care insurers identified above are currently required to have an appeals mechanism that conforms to the requirements of A.R.S. § 20-2530 *et seq.* ("the health care appeals law.") The Department is concerned that some insurers may not be providing their insureds with the required appeals process. This Circular Letter is meant to eliminate any remaining confusion as to the applicability of the health care appeals law, to advise insurers of deficiencies the Insurance Department is encountering with implementation of the law, and to alert insurers to the potential regulatory consequences of failing to comply with the law. This circular letter also discusses the changes resulting from Laws 1999, Ch. 61 (SB 1224), the utilization review omnibus bill.

APPLICABILITY AND DEFINITIONS OF KEY TERMS

The health care appeals law has broad application and is not limited to the activities of HMOs. A.R.S. §20-2531 requires each utilization review agent¹ and each health care insurer² whose utilization review ("UR") system³ may result in direct or indirect denials of requested medical or health care services or claims for services to adopt written utilization review standards, criteria, and processes for the review, reconsideration and appeal of denied requests.

¹ "Utilization review agent means a person or entity that performs utilization review," but excluding governmental agencies and their agents, and employees of a UR agent. A.R.S. § 20-2501(A)(13) (as renumbered in SB 1224).

² "Health care insurer" is defined as "a disability insurer, group disability insurer, blanket disability insurer, benefit insurer, health care services organization, hospital service corporation, prepaid dental plan organization, medical service corporation, dental service corporation or optometric service corporation or a hospital, medical, dental and optometric service corporation." A.R.S. § 20-2501(A)(8) (as renumbered).

³ "Utilization review" is defined as "a system for reviewing the appropriate and efficient allocation of inpatient hospital resources, inpatient medical services and outpatient surgery services that are being given or are proposed to be given to a patient, and of any medical, surgical and health care services or claims for services that may be covered by a health care insurer depending on determinable contingencies, including without limitation outpatient services, in-office consultations with medical specialists, specialized diagnostic testing, mental health services, emergency care and inpatient and outpatient hospital services [but excluding] elective requests for the clarification of coverage." A.R.S. §20-2501(A)(12) (as renumbered).

The law does not exclude Medicare supplement insurance, hospital/surgical policies, or similar "limited-benefit coverage." Entities offering such insurance coverage must provide an appeals process. Arizona residents who have insurance through out-of-state group policies are also entitled to appeal under Arizona's process.

Under current law, only utilization review performed under contract with the federal government for Medicare, self-insured or self-funded employee benefit plans under ERISA, work-related injuries, and illnesses covered under Workers' Compensation laws are excluded from the process. Also not appealable are disputes over claim adjustments for usual and customary charges, coordination of benefits provisions, and enforcement of a health care insurer's deductibles or coinsurance requirements.⁴ The Department treats any appeal requests on these issues as consumer complaints and not as health care appeals.

Laws 1995, Ch. 61 (SB 1224), effective August 6, 1999, adds another exception to the health care appeals law. Disability policies that pay benefits based on the health status of the insured and do not reimburse the cost of or provide covered services will no longer be subject to an appeal process. A.R.S. § 20-2501(A)(2) in SB 1224 defines "benefits based on the health status of the insured" as:

a contract of insurance to pay a fixed benefit amount, without regard to the specific services received, to a policyholder who meets certain eligibility criteria based on health status, including:

(a) A disability income insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is deemed disabled as defined by the policy terms.

(b) A hospital indemnity policy that pays a fixed daily benefit during hospital confinement.

(c) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is certified by a licensed health care professional as chronically ill as defined by the policy terms.

(d) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who suffers from a prolonged physical illness, disability or cognitive disorder as defined by the policy terms.

Under this new exemption, insurers offering disability income, hospital indemnity, and long-term care insurance policies will no longer be required to offer an appeals process on contracts that pay fixed benefit amounts and do not reimburse expenses for covered services.

Plainly, the health care appeals law applies to a broad array of activities and insurers; some insurers may not view their activities as constituting "utilization review" as they may understand that term. The Department strongly cautions all health care insurers to review their activities in light of the expansive definitions in the health care appeals law. Any health care insurer or utilization review agent whose activities fit within the law must provide insureds with an appellate process in compliance with the law.

⁴ Please refer to the definitions of "denial," "claim" and "adverse decision" in A.R.S. §20-2501 for further clarification of these exceptions.

SUPERVISION OF UTILIZATION REVIEW ACTIVITIES

SB 1224 also amended A.R.S. § 20-2508. Current law requires a UR agent to have an allopathic or osteopathic physician available to supervise all UR activities. SB 1224 permits a dental service corporation and a prepaid dental plan to have a licensed dentist supervise or conduct UR activities for dental services and permits an optometric service corporation to have a licensed optometrist supervise or conduct UR activities for optometric services.

REGULATORY ENFORCEMENT ACTIONS TO DETERMINE COMPLIANCE

To date, the majority of external independent review appeals have come from a small number of health care insurers, most of which are HMOs. The absence of appeals from the broad population of insurers subject to the law has raised Department concern that many disability (or indemnity) health insurers are not providing insureds with the statutorily required appeal information packets and the appeal rights mandated by the health care appeals law. To determine whether health care insurers are fully complying with the health care appeals law the Department will take the following measures:

1. Department staff will conduct random audits of health care insurers.
2. The Department will issue corrective orders identifying deficiencies and areas of non-compliance.
3. In appropriate cases, the Department will assess civil fines for findings of non-compliance.

Audits are expected to begin in July 1999.

PROCEDURAL AND ADMINISTRATIVE DEFICIENCIES

The Department has noted various deficiencies in the external independent reviews filed to date.

Inadequate Records

When submitting cases for external review, UR agents and insurers routinely fail to provide many of the supporting documents expressly required by A.R.S. §20-2537(C)(2). Often, the documents listed below are either missing or incomplete.

1. Medical records. UR agents are required to provide the external reviewer with ALL relevant medical records and supporting documentation used to render the denial decision in a member's case.

2. Evidence of coverage or policy form. UR agents are required to provide a COMPLETE copy of the insured's policy or evidence of coverage, not merely selected portions.

3. A summary description of the applicable issues including a statement of the UR agent's decision, the criteria used, and the clinical reasons for the decision. The UR agent should include all correspondence between the insured and the insurer about the appeal. If an appeal involves prescription drug coverage, a copy of the plan formulary and any exclusion lists or guidelines should be submitted. SB 1224 adds a new requirement: The UR agent must provide the Department with a copy of the full summary description, as well as any transmittal correspondence the UR agent sends to the independent reviewer.

4. Relevant portions of the UR agent's utilization review plan.

Failure to Comply With Statutory Time Frames

Another area of deficiency is failure to provide the required notifications and acknowledgments within statutory time frames. A.R.S. § 20-2537 prescribes explicit time periods for the UR agent to provide acknowledgments and notice of decisions to insureds, treating providers, and the Director of the Department of Insurance. Specifically, in medical necessity cases, the UR agent has 5 business days to advise the Director of both the request for external independent review and the name of the chosen reviewer. The external reviewer then has 30 days from the date external review is requested to issue a

decision. Under SB 1224, the UR agent will have an additional 3 business days (beyond the 30th day) to mail notice of the reviewer's decision to the Director, the insured, and the insured's treating provider. The Department requires compliance with all statutory time frames.

Breach of Confidentiality

In some cases sent out for external medical review, UR agents and insurers have not protected the identities of the insured and the insured's treating provider(s). A.R.S. §20-2537(H)(3) prohibits the medical reviewer from knowing the identity of the insured and any treating provider. The UR agent and insurer are required, however, to disclose the identity of the insured and the provider to the Department. Insurers and UR agents must take appropriate precautions to make sure that external medical reviewers do not know the identities of persons involved in the cases on review.

Failure to Advise of Appeal Rights and to Justify Decisions

Some insurers are not providing a clear rationale for decisions upholding denials. If an appeal is denied after an expedited medical review, informal reconsideration or formal appeal, the insurer must document and disclose the criteria used and the clinical reasons for the decision. (See A.R.S. §§ 20-2534(B), 20-2535(F) and 20-2536(E).) For denials based on coverage, the insurer must cite the specific sections of the policy supporting the insurer's decision in the notification to the insured. In denial letters, insurers must expressly inform insureds of the right to appeal the denial to the next level of the process.

Lack of Professional Medical Review

At the formal appeal level, A.R.S. §20-2536(D) requires that a licensed physician (or other health care professional as listed in the statute) review the appeal and render the decision. At this level, an insurer may not permit someone other than a licensed physician or medical professional licensed under one of the other designated statutory categories to make the decision to deny a claim or service.

OTHER ADMINISTRATIVE MATTERS

The Department has created a Transmittal Form for insurers to use when notifying the Department of a request for external independent review. UR agents and insurers must send the Department this form with any external independent reviews involving coverage issues. The form should also be used as notification when cases are sent to external independent medical reviewers. A copy of the Transmittal Form is attached to this Circular Letter.

The list of external independent medical reviewers was published May 21, 1999 in the *Arizona Administrative Register* in accordance with A.R.S. §20-2538(A). The list is also available on the Department of Insurance website at: www.state.az.us/id/Publications.htm. After entering the website, look under Information Brochures, and then under Arizona HealthCare Appeals External Independent Reviewers.

The Department plans to hold a training session in September 1999 to help educate insurers and their employees and utilization review agents about the health care appeals process. All health care insurers, utilization review agents and any other interested parties will be invited to send representatives to the training session, which will be available free of charge. Further information will be provided as it becomes available.

Please direct any questions regarding this circular letter to Mary Butterfield, Assistant Director of the Department's Life & Health Division at 912-4621.

STATE OF ARIZONA HEALTH CARE APPEALS TRANSMITTAL FORM

Insured Member's Name _____
Insured's Member I.D. # _____
Insured's Street Address _____
City, State, Zip Code _____
Insured's Telephone # _____

Insurer's Name _____
Insurer NAIC # _____ Contact Person _____
Insurer's Street Address _____
City, State, Zip Code _____
Telephone # _____ FAX # _____

Utilization Review Agent _____
UR Agent's Street Address _____
City, State, Zip Code _____
UR Agent Telephone # _____ FAX # _____
Contact Person _____

External Review requested by: insured member insurer UR Agent DOI
Date External Review requested _____
Check the last level of appeal completed:
 Expedited Informal Reconsideration Formal Appeal
Date the last appeal level completed _____
Has the insured completed all applicable internal company appeals? Yes No
Decision to deny or not authorize service or claim was made by:
 Insurance Company Health Care Services Org. UR Agent

- For **questions of coverage**, please include all of the following:
1. Copy of the insured's policy, evidence of coverage or similar document
 2. All relevant medical records
 3. Supporting documentation used to render the decision
 4. Summary description of the applicable issues
 5. A statement of the utilization review agent's or insurer's decision
 6. The utilization review agent's or insurer's criteria used and the clinical reasons for the decision
 7. The relevant portions of the utilization review agent's utilization review plan

For **medical necessity** issues, please provide the following:

External Reviewer's Name _____
Reviewer's Street Address _____
City, State, Zip Code _____
Reviewer's Telephone # _____ FAX # _____

Director's Use Only

Date Received _____ Case # _____
Date DOI Review Completed _____ Analyst _____
Date External Reviewer's decision received _____
Medical Necessity Coverage Issue Unable to determine/send for External Review
Denial upheld Denial overturned Partially upheld/overturned